



**First Health**  
**Services Corporation®**

*A Coventry Health Care Company*

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# Kentucky Medicaid Pharmacy Provider Manual

Version 1.1

July 1, 2007

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Please refer to the Final Privacy Rule published in the Federal Register on December 28, 2000, for regulatory details about permitted uses and disclosures of PHI.

## Revision History

Document Version	Date	Name	Comments
1.0	12/04/2004	FHSC Kentucky Pharmacy	Initial creation of document
1.1	07/01/2007	FHSC Kentucky Pharmacy	Revised

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## **1.0 Introduction**

Providers began submitting claims through First Health Services Corporation (FHSC) on December 4, 2004.

The Point-of-Sale (POS) system will require pharmacies to submit claims to First Health Services (FHS) electronically in the National Council for Prescription Drug Programs (NCPDP) standardized Version 5.1; lower versions will not be accepted. After submission, First Health Services will respond to the pharmacy provider with information regarding member eligibility, the Kentucky Department for Medicaid Services allowed amount, applicable Prospective Drug Utilization Review (ProDUR) messages, and applicable Rejection messages. ProDUR messages will be returned in the DUR response fields; other important related information will be displayed in the free-form message area. It is of utmost importance that all providers see the appropriate messages exactly as First Health Services returns them.

In addition to POS claims, First Health Services will accept claims from approved providers via electronic batch on diskettes or through FTP. The format for electronic media is NCPDP Batch 1.1. Paper claims will also be accepted. In those cases where a paper claim is needed, First Health Services will require a Universal Claim Form (UCF). Approved providers may submit claims directly using web-based claim entry.

All arrangements with switching companies should be handled directly by the provider with their preferred switching company.

## 1.1 Important Telephone Numbers

Responsibility	Help Desk	Phone Numbers	Availability
Kentucky Medicaid Pharmacy Website	FHS	<a href="http://kentucky.fhsc.com/pharmacy/default.asp">http://kentucky.fhsc.com/pharmacy/default.asp</a>	<ul style="list-style-type: none"> <li>Preferred Drug List</li> <li>MAC Price List</li> <li>Provider Notices</li> <li>Prior Authorization Forms</li> </ul>
KyHealth Choices Member Services	FHS/KY	800-635-2570	8:00 a.m. – 6:00 p.m., ET Monday - Friday
Clinical Call Center (Prior Authorization Help Desk)	FHS/Managed Access Program Call Center	800-477-3071 (voice)	24 hours
		800-365-8835 (fax: NORMAL)	24 hours
		800-421-9064 (fax: URGENT)	24 hours
		800-453-2273 (fax: LTC/MH)	24 hours
Technical Call Center (Provider Help Desk)	FHS/Technical Call Center	800-432-7005	24 hours
MAC Pricing	FHS	MAC price look-up: <a href="http://kentucky.fhsc.com/pharmacy/providers/mac.asp">http://kentucky.fhsc.com/pharmacy/providers/mac.asp</a>  To appeal MAC pricing: fax: 804-217-7911 or email: <a href="mailto:rebate@fhsc.com">rebate@fhsc.com</a>	24 hours
Software Vendor Certification	FHS	804-217-5060  <a href="mailto:CWEstes@cvty.com">CWEstes@cvty.com</a>	Carrie Estes 9:00 a.m.- 5:00 p.m., ET Monday - Friday
Voice Response Eligibility Verification (VRSV) - Member Eligibility	KY	800-807-1301	
Provider Management/Enrollment	FHS/KY	800-639-5195	

<b>Responsibility</b>	<b>Help Desk</b>	<b>Phone Numbers</b>	<b>Availability</b>
Provider Relations	FHS/KY	502-607-8311	Karen Robinson 8:00 a.m. – 4:00 p.m., ET Monday - Friday
Universal Claim Forms	To request additional forms	800-635-9500 (ex. of one place to order forms)	Moore Wallace (ex. of one place to order forms)
First Health Services Clinical Manager	FHS	502-607-8311	Ronnie Sampere, RPh
First Health Services Account Manager	FHS		

## 1.2 Addresses

Address	Format
<b>Provider Paper Claims Billing Address:</b> First Health Services Corporation Kentucky Medicaid Paper Claims Processing Unit P.O. Box C-85042 Richmond, VA 23261-5042	Universal Claim Form (UCF)
<b>Diskette Claims Address:</b> First Health Services Corporation Attn: Kentucky Media Control 4300 Cox Road Glen Allen, VA 23060	NCPDP Batch 1.1
<b>FTP:</b> First Health Services Corporation 804-290-8371 (fax forms)	NCPDP Batch 1.1
<b>Direct Data Entry (Web):</b> Carrie Estes 804-217-5060 <a href="mailto:CWEstes@cvty.com">CWEstes@cvty.com</a>	NCPDP version 5.1

### Paper Claims Billing Instructions

See *Appendix A: Universal Claim Form*.

### Website

<http://www.chfs.ky.gov/dms/>

<http://kentucky.fhsc.com> or <http://kentucky.fhsc.com/pharmacy/default.asp>

### Software Vendor

**Note:** Software vendors must be certified with First Health Services to submit NCPDP version 5.1. If you have any questions or need assistance in any way, please contact (804) 217-5060 or email [Vendor\\_Certification@fhsc.com](mailto:Vendor_Certification@fhsc.com).

## **1.3 Service Support**

### **Online Certification**

Effective December 4, 2004, any enrolled Kentucky Medicaid network provider may submit claims.

### **Online System Not Available**

If for any reason the online system is not available, providers should submit claims when the online capability resumes. To facilitate this process, the provider's software should have the capability to submit backdated claims.

### **Technical Problem Resolution**

To resolve technical problems, providers should follow the steps outlined below:

1. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational. Call the telephone number the modem is dialing and note the information heard (i.e. fast busy, steady busy, recorded message). Contact the software vendor if unable to access this information in the system.
2. If the pharmacy provider has an internal Technical Support Department, the provider should forward the problem to that department. The pharmacy's technical support staff will coordinate with First Health Services to resolve the problem.
3. If the pharmacy provider's network is experiencing technical problems, the pharmacy provider should contact the network's technical support area. The network's technical support staff will coordinate with First Health Services to resolve the problem.
4. If unable to resolve the problem after following the steps outlined above, the pharmacy provider should contact the First Health Services Technical Call Center at:

**First Health Services Technical Call Center**  
**1-800-432-7005**  
**(Nationwide Toll Free Number)**

## **2.0 Program Setup**

### **2.1 Claim Format**

- Point-of-Sale (POS) claims must be submitted in the NCPDP version 5.1 format.
- Batch claims must be submitted in the NCPDP Batch 1.1 format.
- The Universal Claim Form (UCF) must be submitted for paper submissions. See *Appendix A* for sample UCF and instructions.

### **2.2 Media Options**

- Point-of-Sale (POS)
- Direct Data Entry (web)
- Batch
- Provider Submitted Paper

### **2.3 Networks**

- Per-Se
- QS1
- Emdeon

## 2.4 Transaction Types

The following transaction codes are defined according to the standards established by the NCPDP. The ability to use these transaction codes will depend on the pharmacy's software. At a minimum, all providers should have the capability to submit original claims (Transaction Code B1) and reversals (Transaction Code B2). Additionally, First Health Services will also accept re-bill claims (Transaction Code B3).

### Full Claims Adjudication (Transaction Code B1)

This transaction captures and processes the claim and returns to the pharmacy the dollar amount allowed under the Kentucky Department for Medicaid Services reimbursement formula. B1 corresponds to the "01-04" Transactions supported by version 3.2/3C.

### Claims Reversal (Transaction Code B2)

This transaction is used by the pharmacy to cancel a claim that was previously processed. To submit a reversal, the provider must void a claim that has received a **Paid** status. To reverse a claim, the provider selects the Reversal (Void) option in the pharmacy's computer system. B2 corresponds to the "11" Transaction supported by version 3.2/3C.

**Note:** The following fields must match on the original paid claim and on the void request for a successful claim reversal:

- ❖ Service Provider ID
- ❖ Prescription Number
- ❖ Date of Service (date filled)
- ❖ NDC

### Claims Re-bill (Transaction Code B3)

This transaction is used by the pharmacy to adjust and resubmit a claim that has previously been processed and received a **Paid** status. A "claims re-bill" voids the original claim and resubmits the claim within a single transaction. B3 corresponds to the "31-34" Transactions supported by version 3.2/3C. A complete listing of all transactions supported in NCPDP version 5.1 is on the following page.

### Eligibility Verification (Transaction Code E1)

This transaction is used by the pharmacy to determine a member's eligibility in the program. This transaction is rarely used, as this information is provided as part of the claim transaction.

## 2.5 Version 5.1 Transactions

Please review the following for program requirements; some transactions may be required at a future date to be determined:

<b>NCPDP Lower Version Transaction Code</b>	<b>NCPDP Lower Version Transaction Name</b>	<b>NCPDP Version 5.1 Transaction Code</b>	<b>NCPDP Version 5.1 Transaction Name</b>	<b>Transaction Support Requirements</b>
00	Eligibility Verification	E1	Eligibility Verification	Supported <12/04/2004>.
01 - 04	Rx Billing	B1	Billing	Required <12/04/2004>.
11	Rx Reversal	B2	Reversal	Required <12/04/2004>.
21 - 24	Rx Downtime Billing	N/A	N/A	Not supported in version 5.1.
31 - 34	Rx Re-billing	B3	Re-bill	Required <12/04/2004>.
41	Prior Authorization Request with Request for Payment	P1	Prior Authorization Request and Billing	Not required.
45	Prior Authorization Inquiry	P3	Prior Authorization Inquiry	Not required.
46	Prior Authorization Reversal	P2	Prior Authorization Reversal	Not required.
51	Prior Authorization Request Only	P4	Prior Authorization Request Only	Not required.

## 2.6 Version 5.1 Segments

Data in NCPDP version 5.1 is grouped together in segments. Please review the following for program requirements; some segments may be required at a future date to be determined.

NCPDP									Segment Support Requirements
Request Segment Matrix									
Segment	Transaction Code								Some segments may be required at a future date to be determined.
	E1	B1	B2	B3	P1	P2	P3	P4	
Header	M	M	M	M	M	M	M	M	Required <12/04/2004>.
Patient	S	S	S	S	S	S	S	S	Required <12/04/2004>.
Insurance	M	M	S	M	M	S	M	M	Required <12/04/2004>.
Claim	N	M	M	M	M	M	M	M	Required <12/04/2004>.
Pharmacy Provider	S	S	N	S	S	S	S	S	No planned requirements at this time; may be required at a future date.
Prescriber	N	S	N	S	S	S	S	S	Required <12/04/2004>.
COB/ Other Payments	N	S	N	S	S	N	S	S	Required <12/04/2004>.
Worker’s Comp	N	S	N	S	S	S	S	S	Not required.
DUR/ PPS	N	S	S	S	S	S	S	S	Required <12/04/2004>.
Pricing	N	M	S	M	M	S	S	S	Required <12/04/2004>.
Coupon	N	S	N	S	S	S	S	S	No planned requirements at this time; may be required at a future date.
Compound	N	S	N	S	S	S	S	S	Required <02/01/2005>.
PA	N	S	N	S	M	S	M	M	No planned requirements at this time; may be required at a future date.
Clinical	N	S	N	S	S	N	N	S	Required <12/04/2004>.

### NCPDP Designations

- **M** = Mandatory
- **S** = Situational
- **N** = Not Sent

**Note:** Some segments indicated as “Situational” by NCPDP may be “Required” to support specific transactions for this program.

## 2.7 Required Data Elements

The First Health Services system has program-specific “mandatory/required,” “situational,” and “not sent” data elements for each transaction. The pharmacy provider’s software vendor will need the Payer Specifications before setting up the plan in the pharmacy’s computer system. This will allow the provider access to the required fields. Please note the following descriptions regarding data elements:

Code	Description
<b>M</b>	Designated as <b>MANDATORY</b> in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. These fields must be sent if the segment is required for the transaction.
<b>S</b>	Designated as <b>SITUATIONAL</b> in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. It is necessary to send these fields in noted situations. Some fields designated as situational by NCPDP may be required for all Kentucky Medicaid transactions.
<b>R***</b>	The “R***” indicates that the field is <b>REPEATING</b> . One of the other designators, “M,” or “S” will precede it.

### Kentucky Medicaid claims will not be processed without all the required data elements.

Required fields may or may not be used in the adjudication process. The complete Kentucky Medicaid Payer Specifications, including NCPDP field number references, is in *Appendix B*. Fields “not required for this program” at this time may be required at a future date.

**Note:** The following list provides important identification numbers for this program:

<b>ANSI BIN #</b>	011529
<b>Processor Control #</b>	P022011529
<b>Group #</b>	KYMEDICAID
<b>Provider ID #</b>	Kentucky Medicaid 10-digit Provider Number includes 2 trailing zeros (e.g., 12345678 should be submitted as 1234567800) or the National Provider Identifier (NPI) when directed by Kentucky Medicaid
<b>Cardholder ID #</b>	Kentucky Medicaid Identification Number or Temporary ID
<b>Prescriber ID #</b>	State License Number or the National Provider Identifier (NPI) when directed by Kentucky Medicaid
<b>Product Code</b>	National Drug Code (NDC)

## 2.8 Timely Filing Limits

Point-of-Sale (POS) claims are generally submitted at the time of dispensing. However, there may be mitigating circumstances that require a claim to be submitted after being dispensed.

- For all original claims, reversals, and adjustments, the timely filing limit from the date of service (DOS) is 366 days.
- Claims that exceed the prescribed timely filing limit will **deny** with NCPDP Error Code 81/*Timely Filing Exceeded*. Requests for overrides of Timely Filing Limits should be directed to the First Health Services Technical Call Center.

## 3.0 Program Particulars

### 3.1 Dispensing Limits

#### Days Supply

- Per Rx maximum = 32 days.
- **Exceptions:**
  - ❑ **Maintenance Drugs:**
    - ❖ The Kentucky Department for Medicaid Services has identified and approved a list of approved maintenance drug classes. For more information, please see the following website: <https://kentucky.fhsc.com/pharmacy/providers/druginfo.asp>.
    - ❖ For those drugs, providers should dispense up to a 93-day supply and 100 units as per the prescriber's directions.

#### Maximum Quantity

- Designated drugs are limited to specific quantities. These drugs are identified in a list approved by the Kentucky Department for Medicaid Services and posted on the website, <https://kentucky.fhsc.com/pharmacy/providers/druginfo.asp>.
- Quantity limits may be per fill or cumulative over a designated timeframe.
- Providers should submit a Prior Authorization request for override consideration.

#### Maximum Duration

- Designated drugs are limited to a maximum annual or lifetime duration of therapy. These drugs are identified in a list approved by the Kentucky Department for Medicaid Services and posted on the website, <https://kentucky.fhsc.com/pharmacy/providers/druginfo.asp>.
- Providers should submit a Prior Authorization request for override consideration.

#### Refills

- **Non-controlled drugs:** limited to an original plus up to 11 refills within 366 days from original Date Rx Written.
- **Schedule II:** no refills allowed.
- **Schedule III - IV - V:** limited to an original plus 5 refills within 180 days from original Date Rx Written.
- Long Term Care (LTC) providers should refer to the *Long Term Care Provider Supplement* on the website, <https://kentucky.fhsc.com/pharmacy/providers/manuals.asp>.

## Partial Fills

- In those cases where a provider does not dispense the full amount per the prescriber's directions, the pharmacy provider should submit the claim as a partial fill and indicate as such on the claim transaction.
- The dispense fees will be prorated based on the actual quantity dispensed as indicated on the incoming claim.
- The co-payment, if applicable, will be prorated based on the actual quantity dispensed as indicated on the incoming claim.
- Long Term Care (LTC) providers should refer to the *Long Term Care Provider Supplement* on the website, <https://kentucky.fhsc.com/pharmacy/providers/manuals.asp>.

## Age

- **Prenatal Vitamins:** limited to 50 years old and under.
- **Multi-Vitamins w/ Fluoride:** limited to 16 years old and under.
- Designated drugs are subject to age edits. These drugs are identified in a list approved by the Kentucky Department for Medicaid Services and posted on the website, <https://kentucky.fhsc.com/pharmacy/providers/druginfo.asp>.

## Gender

- **Prenatal vitamins:** limited to females.

## Dollar Limit

- Claims with a dollar amount greater than \$5,000 will deny and return NCPDP Error Code 78/*Cost Exceeds Maximum*.
  - ☐ Providers should validate that the appropriate quantity was entered.
  - ☐ Providers may contact the Technical Call Center for override consideration.

## Diagnosis Code

- Providers should enter the appropriate ICD-9 code to indicate the patient's diagnosis when required.

## 3-Brand Drug Allowance

- Effective March 2005, members will be allowed three brand scripts per rolling 26 days. On the fourth brand script, the claim will deny NCPDP Error Code 76/*Plan Limitations Exceeded*, with additional messaging "3 brand allowance met/resubmit w/valid PA MD Type Code." Providers may override the three brand script limitation using a PRIOR AUTHORIZATION TYPE CODE = "05."

- Members who are less than 19 years old will be exempt from the three brand script limitation.
- Insulin products (defined by Drug Category Code = “I” and route of administration = Intravenous, Intramuscular, Injection, Intradermal, or Subcutaneous) are exempt from the three brand script limitation.
- Pharmacists can utilize the Point-of-Sale (POS) 3 brand prescription limit pharmacy claim override “05” when:
  - ☐ The member’s monthly 3 brand prescription limit has been exceeded, **and**
  - ☐ The prescription, in the pharmacist’s professional judgment, is for a life threatening medical condition that, **if medication is not dispensed**, could result in hospitalization or place the member in jeopardy.

#### 4-Prescription Limit

- Effective March 1, 2006, members will be allowed four scripts per rolling 26 days without regard to brand or generic status. On the fifth script, the claim will deny NCPDP Error Code 75/*Prior Authorization Required* with additional messaging “4 Script Limit Met/Use Valid Code.” Providers may override the four script limitation using a SUBMISSION CLARIFICATION CODE = “07.”
- Exception to the four prescription rule may be made for certain medical conditions -- *see Provider Notice #022* (or the most recent Provider Notice addressing the four script limit) on the Kentucky pharmacy website:  
<http://kentucky.fhsc.com/pharmacy/providers/bulletins.asp>.
- Exception to the four prescription rule may be made for certain therapeutic classes of drugs and medications listed in *Provider Notice #038* (or the most recent Provider Notice addressing the four script limit) on the Kentucky pharmacy website:  
<http://kentucky.fhsc.com/pharmacy/providers/bulletins.asp>.
- Members who are less than 19 years old will be exempt from the four script limitation.
- Insulin products (Defined by Drug Category Code = “I” and route of administration = Intravenous, Intramuscular, Injection, Intradermal, or Subcutaneous) are exempt from the four script limitation.
- Pharmacists can utilize the Point-of-Sale (POS) 4 prescription limit pharmacy claim override “07” when:
  - ☐ The member’s monthly 4 prescription limit has been exceeded, **and**
  - ☐ The member’s prescription is for a drug that has an FDA indication to treat one of the medical conditions listed in *Provider Notice #022* (or the most recent Provider Notice addressing the four script limit). Provider Notices can be found at the

Kentucky pharmacy website:

<http://kentucky.fhsc.com/pharmacy/providers/bulletins.asp>, or

- ❑ The prescription, in the pharmacist's professional judgment, is for a life threatening medical condition that, **if medication is not dispensed**, could result in hospitalization or place the member in jeopardy.

## 3.2 Mandatory Generic Requirements

- **Providers should dispense generic drugs whenever appropriate.**
- Multi-source brand drugs without a MAC will require prior authorization.

## 3.3 Proprietary Maximum Allowable Cost (MAC) Program

The Maximum Allowable Cost (MAC) Program is a service developed and maintained by First Health Services for use by the Kentucky Department for Medicaid Services. Its purpose is to encourage a provider to use a less expensive therapeutically equivalent drug. First Health Services Clinical Management Consultants regularly review the current drug price sources. A drug may be considered for MAC pricing if there are 2 or more manufacturers and it is listed as multi-source. Other factors considered are therapeutic equivalency ratings and availability in the marketplace. The MAC pricing is updated monthly. The specific drug pricing resources, algorithm, and MAC prices are proprietary and confidential. Distribution and access to this information is therefore limited to prevent First Health Services competitors from obtaining free access to the information, which would result in not having to incur the costs associated with developing, maintaining, or licensing their own MAC service.

The full Maximum Allowable Cost (MAC) List in PDF format can be found at <http://kentucky.fhsc.com/pharmacy/providers/mac.asp>. To access the list, the provider must click on the "OK" button to agree with the Confidentiality Terms and Conditions of Use statement on the website that the information received is for use in billing by Medicaid Providers only and that any unauthorized reproduction, distribution, or other use of the MAC list is strictly prohibited. Another option is using the *Request for the Kentucky Maximum Allowable Cost (MAC) List* form that can be found at <http://kentucky.fhsc.com/pharmacy/providers/forms.asp> or via fax from the First Health Services Technical Call Center (Help Desk) at 1-800-432-7005. The provider must print and complete the form. Upon signing the acceptance of the Confidentiality Terms, the provider can mail the form to First Health Services and receive a copy of the MAC list. These options are designed to protect the proprietary nature of the MAC service.

If a provider does not think a MAC price is valid, he/she may appeal the price by emailing or faxing a completed *MAC Price Inquiries and Research Form* (located at <http://kentucky.fhsc.com/pharmacy/providers/forms.asp>) to the First Health Services MAC

Department. If a provider does not have internet access, he/she can call the First Health Services Technical Call Center to request that the form be faxed to him/her. If available, the provider will be supplied with 1 or more manufacturers that have a price comparable to the MAC price. If it is determined that there are no longer any manufacturers in that price range or if the provider can document that he/she does not have access to the supplied manufacturers, the MAC price and effective date will be adjusted accordingly, retroactive to the date of service for the MAC price prescription in question or other relevant date. Once the change is in effect, the provider will be informed and he/she can re-bill the claim for the price adjustment.

## **3.4 Drug Coverage**

### **Included**

- All federal legend drugs and rebatable OTCs\*.

\* A prescription is required for covered OTCs.

### **Excluded**

- DESI, IRS, or LTE drugs
- Diagnostics
- Supplies
- Non-rebatable products except for covered vitamins and vaccines
- Herbals
- Blood plasma products
- Topical contraceptives
- Nutritional/Dietary supplements
- Drugs used for anorexia, weight loss, or weight gain
- Drugs used to promote fertility
- Drugs used for cosmetic purpose of hair growth
- Drugs used to promote smoking cessation
- Vitamin or mineral products other than prenats or fluoride preparations (fluoride not covered over age 16)

### **Nursing Home Per Diem**

- See *Long Term Care Provider Supplement* on the website,  
<https://kentucky.fhsc.com/pharmacy/providers/manuals.asp>.

### **Prior Authorization**

- Designated drugs require Prior Authorization. These drugs are identified in a list approved by the Kentucky Department for Medicaid Services and posted on the website, <https://kentucky.fhsc.com/pharmacy/providers/druginfo.asp>.
- Providers should submit a Prior Authorization request for override consideration.

### **Preferred Drug List (PDL)**

- Designated drugs are considered non-preferred. These drugs are identified in a list approved by the Kentucky Department for Medicaid Services and posted on the website, <https://kentucky.fhsc.com/pharmacy/providers/druginfo.asp>.
- Providers should submit a Prior Authorization request for override consideration.

### **Step Therapy**

- Designated drugs require step therapy. These drugs are identified in a list approved by the Kentucky Department for Medicaid Services and posted on the website, <https://kentucky.fhsc.com/pharmacy/providers/druginfo.asp>.
- Providers should submit a Prior Authorization request for override consideration.

## 3.5 Member Payment Information

### Co-payment

- There is a standard tiered co-payment structure based upon member's eligibility and benefit package.
- Exceptions to co-payment:
  - ☐ Pregnant women should not have cost sharing for medications. To override/waive a co-payment on each prescription, pharmacists should enter the following pregnancy indicator each time in NCPDP field 335-2C: 2 = pregnant.

Pregnant women should be charged \$0 co-payment for no more than 11 months (including 60 days postpartum). After 60-days postpartum, the pharmacist should stop entering "2" to override co-payment for the fill of current prescriptions. No further action will be required by the pharmacist, and normal co-payment will resume.

- ☐ The system will recognize family planning drugs (contraceptives) and will automatically waive co-payment.

### Annual Benefit Maximum

- There is no annual benefit maximum.

### Deductible

- There is no deductible.

### Annual Out of Pocket Co-payment Cap of \$225

- No member will pay more than \$225 out of pocket for pharmacy co-payments in a calendar year (January 1 through December 31). Sum, balance, and cap appear in Point-of-Sale (POS) messaging.

### Federal Poverty Level

- If a member is at or below 100% of the federal poverty level, a provider cannot refuse to provide services for non-payment of co-payment amounts.
- If the member is above 100% of the federal poverty level, a provider may refuse to provide services if this is the current business practice for all patients. However, if a member presents with a condition that could result in harm to the member if the condition is left untreated, the provider must dispense a 72-hour emergency supply of each required

medication. The member may later return to the pharmacy with the required cost sharing to obtain the remainder of the prescription(s).

- When the provider sees a poverty level indicator Point-of-Sale (POS) message of “Dispense Regardless of Co-payment Collection,” the medication must be dispensed.
- Co-payment amount will continue to appear for members with the poverty level indicator. This allows the provider to collect the correct co-payment amount *if* the member has the ability to pay.
- For more information, see *Provider Notice #044* (or the most recent Provider Notice addressing the federal poverty level) at the Kentucky pharmacy website:  
<http://kentucky.fhsc.com/downloads/providers/ky-providernotice-044-030907.pdf>.

### 3.6 Prior Authorization

The First Health Services Prior Authorization (PA) process is designed to provide rapid, timely responses to prior authorization requests. Prior authorizations will be managed for the Kentucky Department for Medicaid Services by one of three methods:

- First Health Services Clinical Call Center
- First Health Services Technical Call Center
- Direct Pharmacy Level Overrides

The following tables provide the products for each prior authorization method.

Prior Authorization: Clinical Call Center	
<b>Contact the First Health Services Clinical Call Center:</b> 800-477-3071	
<b>PA Request Forms can be found at:</b> <a href="https://kentucky.fhsc.com/pharmacy/providers/forms.asp">https://kentucky.fhsc.com/pharmacy/providers/forms.asp</a>	
Normal FAX:	800-365-8835
Urgent FAX:	800-421-9064
LTC/MH FAX:	800-453-2273
<b>For prior authorization or override consideration regarding the following denial reasons:</b>	
Reason	
<b>Prior Authorization Required</b>	Pharmacy provider or prescriber sends fax using appropriate form.
<b>PDL</b>	Pharmacy provider or prescriber sends fax using appropriate form.
<b>H2RAs</b>	Pharmacy provider or prescriber sends fax using appropriate form.
<b>Quantity/Days Supply/ Dosing Limitations</b>	Pharmacy provider or prescriber sends fax using appropriate form.
<b>Step Therapy</b>	Pharmacy provider or prescriber sends fax using appropriate form.
<b>Brand Necessary</b>	Prescriber sends fax using appropriate form.
<b>Medicare Part B</b>	A claim for a Medicare-covered drug will deny if the member enrollment information indicates that member has Medicare Part B coverage for the DOS. If the drug is being administered for a non-Medicare covered reason, the pharmacy provider or prescriber sends fax using appropriate form.

<b>Prior Authorization/Override: Technical Call Center</b>	
<b>Contact the First Health Services Technical Call Center:</b> 800-432-7005	
<b>For override consideration regarding the following denial reasons:</b>	
<b>Reason</b>	
<b>Dollar Limit</b>	A claim greater than \$5,000 will deny. Providers should first validate that the appropriate quantity has been submitted. Providers should then contact First Health Services Technical Call Center for override consideration.
<b>Timely Filing Limits</b>	A claim exceeding 366 days from the original DOS will deny. Providers should contact First Health Services Technical Call Center for override consideration.
<b>Lock-Ins</b>	Providers should contact the First Health Services Technical Call Center for override consideration.

<b>Provider Level Overrides</b>	
<b>Provider level overrides allowed.</b>	
<b>For override consideration regarding the following denial reasons:</b>	
<b>Reason</b>	
<b>ProDUR</b>	<p>Providers may override the following ProDUR conditions:</p> <ul style="list-style-type: none"> <li>– Therapeutic Duplication (except for atypical antipsychotics)</li> <li>– Duplicate Ingredient</li> <li>– Early Refill</li> <li>– Drug to Drug Interactions</li> </ul> <p>▪ In order to override when approved conditions are met, providers should use appropriate DUR codes to indicate the Reason for Service (Conflict), Professional Service (Intervention), and Result of Service (Outcome).</p>
<b>Emergency</b>	<p>Providers may override Prior Authorization conditions in emergency situations.</p> <p>▪ In order to override when approved conditions are met, providers should enter the appropriate Level of Service code to override.</p>
<b>COB/TPL</b>	<p>Providers may override coordination of benefits (COB) using designated override codes in approved conditions.</p> <p>▪ In order to override when approved conditions are met, providers should enter the appropriate COB codes and/or Prior Authorization Type code.</p>

### 3.7 Emergency Procedures

- All providers should follow normal prior authorization procedures, except in emergency conditions.
- The emergency override is intended for unique circumstances where general prior authorization procedures cannot be followed and the situation is considered life threatening.
- Providers may override PA Requirements by entering LEVEL OF SERVICE (NCPDP Field #418-DI) – “3” (emergency) under the following guidelines:
  - ☐ Overrides must be outside of normal business hours.
  - ☐ Overrides must be for a 3-day supply except where the package must be dispensed intact.
  - ☐ OTCs cannot be overridden.
  - ☐ Drugs normally not covered cannot be overridden.

### 3.8 Coordination of Benefits (COB)

- Online COB (cost avoidance) is required.
- The Kentucky Department for Medicaid Services is always the payer of last resort. Providers must bill all other payers first and then bill the Kentucky Department for Medicaid Services.
- First Health Services will return the following Other Payer details in the “Additional Message” field:
  - ☐ Other Payer ID
  - ☐ Other Payer (carrier) Name
  - ☐ Policy Number
- Reimbursement will be calculated to pay up to the Medicaid allowed amount less the third-party payment.
  - ☐ Claims submitted with PRIOR AUTHORIZATION TYPE CODE (NCPDP Field #461-EU) = “8” (payer defined exemption) will bypass the Third Party Liability (TPL) editing for all carriers and pay (pay and chase).

#### Medicare Part D

On the date that Kentucky Medicaid members become eligible for Medicare Part D, the Kentucky Department for Medicaid Services will only cover three classes of drugs for these dual-eligible individuals:

- Over-the-Counter Medications (OTCs)

- Benzodiazepines
- Barbiturates

(And a few other miscellaneous products not covered by Part D)

### TPL Processing Grid

Other Coverage Code (NCPDP Field # 308-C8)	Claim Disposition	Notes
0 = Not specified		This code will not override TPL File.
1 = No other coverage identified	Allow for override.	Used when primary is billed and responds patient not on file. ▪ NCPDP Error Code 65 (see OCC 7)
2 = Other coverage exists, payment collected	Allow for override.	Used when payment is collected from the primary.
3 = Other coverage exists, claim not covered	Allow for override.	Used when the primary denies the claim for drug not covered. ▪ NCPDP Error Code 70, 73, 76
4 = Other coverage exists, payment not collected	Allow for override.	Used when the primary pays the claim but does not receive anything from the primary due to deductible.
5 = Managed care plan denial	Do not allow for override.	No industry protocols for standard usage.
6 = Other coverage exists, not a participating provider	Allow for override.	Used when the provider is not in the network for the primary. ▪ NCPDP Error Code 40
7 = Other coverage exists, not in effect on DOS	Allow for override.	Used when primary is billed and denies for patient coverage terminated. ▪ NCPDP Error Code 65, 67, 68, 69
8 = Co-payment only	Do not allow for override.	Intended for use in higher NCPDP versions.

### Other Payer Reject Code (NCPDP Field # 472-6E)

“40” - Pharmacy not contracted with plan on date of service.

“65” - Patient is not covered.

“67” - Filled before coverage effective.

“68” - Filled after coverage expired.

“69” - Filled after coverage terminated.

“70” - Product/Service not covered.

“73” - Refills are not covered.

“76” - Plan limitations exceeded.

### 3.9 Long Term Care (LTC)

- Providers should enter PATIENT LOCATION CODE (NCPDP Field #307-C7) = “3” (Nursing Home) in order to identify that the patient is in a Long Term Care (LTC) facility.
- Providers should indicate pharmacy repackaging by entering a UNIT DOSE INDICATOR (NCPDP Field #429-DT) = “03” and the appropriate amount in the INCENTIVE AMOUNT SUBMITTED (NCPDP Field #438-E3). The cap is \$25.00 per Rx.
- See the *Long Term Care Provider Supplement* on the website, <https://kentucky.fhsc.com/pharmacy/providers/manuals.asp> for additional information.

### 3.10 Medicare Covered Drugs

- Medicare Part B and Part D drugs will not be covered by the Kentucky Department for Medicaid Services. These claims will deny with NCPDP Error Code 41 and the supplemental message of “Submit bill to other process or primary payer” with the additional message: “Bill Medicare Part D; Other payer not cost avoided.”
- Crossover billing is not part of the POS system.

### 3.11 Compounds or Home IV

- Method of Submission (since 2/1/05) for Compound Prescription – **Must use Multi-Ingredient Compound Segment:**
  - ☐ On the Product/Service screen, enter 11 zeros (00000000000) in the Product/Incoming ID/NDC field
  - ☐ Enter the “compound code” of “2”
  - ☐ On the Compound screen, enter NDCs of all ingredients on one claim, using one Rx number

Fields Required for Submitting Multi-Ingredient Compounds:

#### On CLAIM SEGMENT:

- Enter COMPOUND CODE (NCPDP Field #406-D6) of “2”
- Enter PRODUCT CODE/ NDC (NCPDP Field #407-D7) as “00000000000” on the claim segment to identify the claim as a multi-ingredient compound.
- Enter QUANTITY DISPENSED (NCPDP Field #442-E7) of entire product.
- Enter GROSS AMOUNT DUE (NCPDP Field #430-DU) for entire product.
- SUBMISSION CLARIFICATION CODE (NCPDP Field #420-DK) = Value “8” will **only** be permitted for POS (not valid for paper claims) and should be used only for compounds

with both rebatable and nonrebatable ingredients. This value allows the provider to be reimbursed for rebatable ingredients only. **Use only if claim rejects for “nonrebatable.”**

**On COMPOUND SEGMENT:**

- COMPOUND DOSAGE FORM DESCRIPTION CODE (NCPDP Field # 450-EF)
- COMPOUND DISPENSING UNIT FORM INDICATOR (NCPCP Field #451-EG)
- COMPOUND ROUTE OF ADMINISTRATION (NCPCP Field #452-EH)
- COMPOUND INGREDIENT COMPONENT COUNT (NCPCP Field #447-EC)  
(**Maximum of 25**)

**For Each Line Item:**

- COMPOUND PRODUCT ID QUALIFIER (NCPCP Field #488-RE) of “3”
- COMPOUND PRODUCT ID (NCPDP Field #489-TE)
- COMPOUND INGREDIENT QUANTITY (NCPDP Field #448-ED)
- COMPOUND INGREDIENT COST (NCPDP Field #449-EE)

### **3.12 Lock-In**

- A member may be locked in to a prescriber, pharmacy provider, or both.

## **4.0 Prospective Drug Utilization Review (ProDUR)**

Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of First Health Services assists the pharmacist in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available.

Because First Health Services' ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. First Health Services recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties.

## **4.1 Therapeutic Problems**

Prospective (concurrent) Drug Utilization Review edits apply to all claims unless otherwise identified.

## **4.2 Technical Call Center**

The First Health Services Technical Call Center is available 24 hours per day, seven days a week. The telephone number is 800-432-7005. Alert message information is available from the Technical Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the Technical Call Center about First Health Services ProDUR messages at the time of dispensing. The Technical Call Center can provide claims information on all error messages sent by the ProDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

The First Health Services Technical Call Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. First Health Services has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, First Health Services' staff pharmacists are available for consultation.

First Health Services ProDUR is an integral part of the claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the available medical history, focusing on those patients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate.

### 4.3 ProDUR Alert/Error Messages

All ProDUR alert messages appear at the end of the claims adjudication transmission. Alerts will appear in the following format:

Format	Field Definitions
<b>REASON FOR SERVICE:</b>	2 characters. Code identifying the type of utilization conflict detected; e.g., “TD” (Therapeutic Duplication).
<b>CLINICAL SIGNIFICANCE:</b>	1 character. Code indicating the significance or severity level of a clinical event. 1 = Major 2 = Moderate 3 = Minor
<b>OTHER PHARMACY INDICATOR:</b>	1 character. Indicates if the dispensing provider also dispensed the first drug in question. 0 = No Value 1 = Your pharmacy 3 = Other pharmacy
<b>PREVIOUS DATE OF FILL:</b>	8 characters. Indicates previous fill date of conflicting drug in YYYYMMDD format.
<b>QUANTITY OF PREVIOUS FILL:</b>	5 characters. Indicates quantity of conflicting drug previously dispensed.
<b>DATA BASE INDICATOR:</b>	1 character. Indicates source of ProDUR message. 1 = First DataBank 4 = Processor Developed
<b>OTHER PRESCRIBER:</b>	1 character. Indicates the prescriber of conflicting prescription. 0 = No Value 1 = Same Prescriber 2 = Other Prescriber

## 5.0 Edits

### 5.1 Online Claims Processing Messages

Following an online claim submission by a pharmacy, the system will return a message to indicate the outcome of processing. If the claim passes all edits, a “**Paid**” message will be returned with the Kentucky Department for Medicaid Services allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message. Following is a list of NCPDP rejects and descriptions.

As shown below, an NCPDP error code is returned with an NCPDP message. Where applicable, the NCPDP field that should be checked is referenced. Check the Solutions box if you are experiencing difficulties. For further assistance, contact First Health Services at:

**Technical Call Center**

**1-800-432-7005**

**(Nationwide Toll Free Number)**

#### Point-of-Sale (POS) Reject Codes and Messages:

~ All edits may not apply to this program ~

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
("M/I" Means Missing/Invalid)			
01	M/I Bin	101	Enter 011529.
02	M/I Version Number	102	NCPDP version 5.1 is required.
03	M/I Transaction Code	103	Transactions allowed = B1, B2, B3.
04	M/I Processor Control Number	104	Enter P022011529.
05	M/I Pharmacy Number	201	Enter the Kentucky Medicaid Pharmacy Provider ID or National Provider Identifier (NPI). Check with the software vendor to ensure appropriate number has been set up in your system.
06	M/I Group Number	301	Enter KYMEDICAID.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
07	M/I Cardholder ID Number	302	Enter the Kentucky Medicaid Member ID number only; do not enter any other patient ID. Do not enter any dashes. Providers should always examine a member's ID card before services are rendered. It is the provider's responsibility to establish the identity of the member and to verify the effective date of coverage for the card presented.
08	M/I Person Code	303	
09	M/I Birth Date	304	Format = YYYYMMDD (no dashes).
1C	M/I Smoker/Non-Smoker Code	334	
1E	M/I Prescriber Location Code	467	
10	M/I Patient Gender Code	305	Values: 0 = not specified 1 = male 2 = female
11	M/I Patient Relationship Code	306	1 (cardholder).
12	M/I Patient Location	307	
13	M/I Other Coverage Code	308	See <i>Section 3.8 - Coordination of Benefits</i> .
14	M/I Eligibility Clarification Code	309	
15	M/I Date of Service	401	Format = YYYYMMDD (no dashes). A future date is not allowed in this field.
16	M/I Prescription/Service Reference Number	402	Format = NNNNNNN.
17	M/I Fill Number	403	Enter "0" for a new prescription. Acceptable values for a refill prescription range from 1 to 99.
19	M/I Days Supply	405	Format = NNN. Enter the day's supply, "PRN" is not allowed.
2C	M/I Pregnancy Indicator	335	Enter "2" to indicate the patient is pregnant and to waive co-payment. After 60 days postpartum, stop entering "2" to override co-payment.

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
2E	M/I Primary Care Provider ID Qualifier	468	
20	M/I Compound Code	406	
21	M/I Product/Service ID	407	Enter 11-digit NDC only. Do not enter any dashes.
22	M/I Dispense As Written (DAW)/Product Selection Code	408	Enter “1” to indicate substitution not allowed by prescriber.
23	M/I Ingredient Cost Submitted	409	
25	M/I Prescriber ID	411	Enter the State License Number for the state in which the prescriber practices. Do not enter DEA Number. When National Provider Identifier (NPI) is mandatory, the prescriber NPI must be entered.
26	M/I Unit Of Measure	600	Enter the appropriate Unit of Measure for the product dispensed. Values: EA = each GM = grams ML = milliliters
28	M/I Date Prescription Written	414	Format = YYYYMMDD (no dashes). A future date is not allowed.
29	M/I Number Refills Authorized	415	Enter the number of refills as authorized by the prescriber.
3A	M/I Request Type	498-PA	
3B	M/I Request Period Date-Begin	498-PB	
3C	M/I Request Period Date-End	498-PC	
3D	M/I Basis Of Request	498-PD	
3E	M/I Authorized Representative First Name	498-PE	
3F	M/I Authorized Representative Last Name	498-PF	
3G	M/I Authorized Representative Street Address	498-PG	

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
3H	M/I Authorized Representative City Address	498-PH	
3J	M/I Authorized Representative State/Province Address	498-PJ	
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	
3M	M/I Prescriber Phone Number	498-PM	
3N	M/I Prior Authorized Number Assigned	498-PY	
3P	M/I Authorization Number	503	
3R	Prior Authorization Not Required	407	
3S	M/I Prior Authorization Supporting Documentation	498-PP	
3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization		
3W	Prior Authorization In Process		
3X	Authorization Number Not Found	503	
3Y	Prior Authorization Denied		
32	M/I Level Of Service	418	
33	M/I Prescription Origin Code	419	
34	M/I Submission Clarification Code	420	
35	M/I Primary Care Provider ID	421	
38	M/I Basis Of Cost	423	
39	M/I Diagnosis Code	424	Enter the appropriate ICD-9 code.
4C	M/I Coordination Of Benefits/Other Payments Count	337	
4E	M/I Primary Care Provider Last Name	570	

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
40	Pharmacy Not Contracted With Plan On Date Of Service	None	Enter Kentucky Medicaid Pharmacy Provider ID number or National Provider Identifier (NPI); check DOS. Call the Provider Management/Enrollment Department if necessary (see Section 1.1).
41	Submit Bill To Other Processor Or Primary Payer	None	
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	
50	Non-Matched Pharmacy Number	201	Enter Kentucky Medicaid Pharmacy Provider ID or National Provider Identifier (NPI). Check lock-in status of member.
51	Non-Matched Group ID	301	Enter KYMEDICAID group only.
52	Non-Matched Cardholder ID	302	Enter member's Kentucky Medicaid ID number only; do not enter any other patient ID. Do not enter any dashes.
53	Non-Matched Person Code	303	
54	Non-Matched Product/Service ID Number	407	Enter 11-digit NDC.
55	Non-Matched Product Package Size	407	
56	Non-Matched Prescriber ID	411	Enter State License Number until National Provider Identifier (NPI) is mandatory.
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	422	
6E	M/I Other Payer Reject Code	472	
60	Product/Service Not Covered For Patient Age	302, 304, 401, 407	
61	Product/Service Not Covered For Patient Gender	302, 305, 407	
62	Patient/Card Holder ID Name Mismatch	310, 311, 312, 313, 320	
63	Institutionalized Patient Product/Service ID Not Covered		Drug not covered for member in Long Term Care facility.

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
64	Claim Submitted Does Not Match Prior Authorization	201, 401, 404, 407, 416	
65	Patient Is Not Covered	303, 306	
66	Patient Age Exceeds Maximum Age	303, 304, 306	
67	Filled Before Coverage Effective	401	Enter member's Kentucky Medicaid ID number only; do not enter any other patient ID. Do not enter any dashes. Check DOS. Check Group Number.
68	Filled After Coverage Expired	401	Enter member's Kentucky Medicaid ID number only; do not enter any other patient ID. Do not enter any dashes. Check DOS. Check Group Number.
69	Filled After Coverage Terminated	401	
7C	M/I Other Payer ID	340	
7E	M/I DUR/PPS Code Counter	473	
70	Product/Service Not Covered	407	Enter 11-digit NDC. Drug not covered.
71	Prescriber Is Not Covered	411	
72	Primary Prescriber Is Not Covered	421	
73	Refills Are Not Covered	402, 403	
74	Other Carrier Payment Meets Or Exceeds Payable	409, 410, 442	
75	Prior Authorization Required	462	Validate 11-digit NDC. Follow Prior Authorization procedures if appropriate.
76	Plan Limitations Exceeded	405, 442	Validate days supply and quantity dispensed. Follow Prior Authorization procedures if appropriate.
77	Discontinued Product/Service ID Number	407	Validate 11-digit NDC. NDC is obsolete.
78	Cost Exceeds Maximum	407, 409, 410, 442	Claims will deny if greater than \$5,000. Provider must contact the First Health Services Technical Call Center for override consideration.

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
79	Refill Too Soon	401, 403, 405	80% of days supply from previous claim has not been utilized. Prior fill may be from a different provider.
8C	M/I Facility ID	336	
8E	M/I DUR/PPS Level Of Effort	474	
80	Drug-Diagnosis Mismatch	407, 424	
81	Claim Too Old	401	Check DOS. Contact the First Health Services Technical Call Center for override consideration when appropriate.
82	Claim Is Post-Dated	401	
83	Duplicate Paid/Captured Claim	201, 401, 402, 403, 407	
84	Claim Has Not Been Paid/Captured	201, 401, 402	
85	Claim Not Processed	None	
86	Submit Manual Reversal	None	
87	Reversal Not Processed	None	Provider number, DOS and Rx number must equal original claim.
88	DUR Reject Error		
89	Rejected Claim Fees Paid		
90	Host Hung Up		Processing Host Did Not Accept Transaction/Did Not Respond Within Time Out Period.
91	Host Response Error		
92	System Unavailable/Host Unavailable		
95	Time Out		
96	Scheduled Downtime		
97	Payer Unavailable		
98	Connection To Payer Is Down		
99	Host Processing Error		Do Not Retransmit Claim(s).
AA	Patient Spenddown Not Met		

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
AB	Date Written Is After Date Filled		
AC	Product Not Covered Non-Participating Manufacturer		
AD	Billing Provider Not Eligible To Bill This Claim Type		
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare		
AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation For Product/Service		
AH	Unit Dose Packaging Only Payable For Nursing Home Members		
AJ	Generic Drug Required		
AK	M/I Software Vendor/Certification ID	110	
AM	M/I Segment Identification	111	
A9	M/I Transaction Count	109	
BE	M/I Professional Service Fee Submitted	477	
B2	M/I Service Provider ID Qualifier	202	Enter "05" Medicaid ID or "01" National Provider Identifier (NPI).
CA	M/I Patient First Name	310	
CB	M/I Patient Last Name	311	
CC	M/I Cardholder First Name	312	
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	
CG	M/I Employer Street Address	316	
CH	M/I Employer City Address	317	
CI	M/I Employer State/Province Address	318	

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
CJ	M/I Employer Zip Postal Zone	319	
CK	M/I Employer Phone Number	320	
CL	M/I Employer Contact Name	321	
CM	M/I Patient Street Address	322	
CN	M/I Patient City Address	323	
CO	M/I Patient State/Province Address	324	
CP	M/I Patient Zip/Postal Zone	325	
CQ	M/I Patient Phone Number	326	
CR	M/I Carrier ID	327	
CW	M/I Alternate ID	330	
CX	M/I Patient ID Qualifier	331	
CY	M/I Patient ID	332	
CZ	M/I Employer ID	333	
DC	M/I Dispensing Fee Submitted	412	
DN	M/I Basis Of Cost Determination	423	
DQ	M/I Usual And Customary Charge	426	
DR	M/I Prescriber Last Name	427	
DT	M/I Unit Dose Indicator	429	
DU	M/I Gross Amount Due	430	
DV	M/I Other Payer Amount Paid	431	
DX	M/I Patient Paid Amount Submitted	433	Do not submit any value > 0.
DY	M/I Date Of Injury	434	
DZ	M/I Claim/Reference ID	435	
EA	M/I Originally Prescribed Product/Service Code	445	
EB	M/I Originally Prescribed Quantity	446	
EC	M/I Compound Ingredient Component Count	447	

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
ED	M/I Compound Ingredient Quantity	448	
EE	M/I Compound Ingredient Drug Cost	449	
EF	M/I Compound Dosage Form Description Code	450	
EG	M/I Compound Dispensing Unit Form Indicator	451	
EH	M/I Compound Route Of Administration	452	
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453	
EK	M/I Scheduled Prescription ID Number	454	
EM	M/I Prescription/Service Reference Number Qualifier	445	
EN	M/I Associated Prescription/Service Reference Number	456	
EP	M/I Associated Prescription/Service Date	457	
ER	M/I Procedure Modifier Code	459	
ET	M/I Quantity Prescribed	460	
EU	M/I Prior Authorization Type Code	461	
EV	M/I Prior Authorization Number Submitted	462	
EW	M/I Intermediary Authorization Type ID	463	
EX	M/I Intermediary Authorization ID	464	
EY	M/I Provider ID Qualifier	465	
EZ	M/I Prescriber ID Qualifier	466	Enter “08” State License Number or “01” National Provider Identifier (NPI).

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
E1	M/I Product/Service ID Qualifier	436	
E3	M/I Incentive Amount Submitted	438	
E4	M/I Reason For Service Code	439	
E5	M/I Professional Service Code	440	
E6	M/I Result Of Service Code	441	
E7	M/I Quantity Dispensed	442	
E8	M/I Other Payer Date	443	
E9	M/I Provider ID	444	
FO	M/I Plan ID	524	
GE	M/I Percentage Sales Tax Amount Submitted	482	
HA	M/I Flat Sales Tax Amount Submitted	481	
HB	M/I Other Payer Amount Paid Count	341	
HC	M/I Other Payer Amount Paid Qualifier	342	
HD	M/I Dispensing Status	343	
HE	M/I Percentage Sales Tax Rate Submitted	483	
HF	M/I Quantity Intended To Be Dispensed	344	
HG	M/I Days Supply Intended To Be Dispensed	345	
H1	M/I Measurement Time	495	
H2	M/I Measurement Dimension	496	
H3	M/I Measurement Unit	497	
H4	M/I Measurement Value	499	
H5	M/I Primary Care Provider Location Code	469	
H6	M/I DUR Co-Agent ID	476	

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
H7	M/I Other Amount Claimed Submitted Count	478	
H8	M/I Other Amount Claimed Submitted Qualifier	479	
H9	M/I Other Amount Claimed Submitted	480	
JE	M/I Percentage Sales Tax Basis Submitted	484	
J9	M/I DUR Co-Agent ID Qualifier	475	
KE	M/I Coupon Type	485	
M1	Patient Not Covered In This Aid Category		
M2	Member Locked In		
M3	Host PA/MC Error		
M4	Prescription/Service Reference Number/Time Limit Exceeded		
M5	Requires Manual Claim		
M6	Host Eligibility Error		
M7	Host Drug File Error		
M8	Host Provider File Error		
ME	M/I Coupon Number	486	
MZ	Error Overflow		
NE	M/I Coupon Value Amount	487	
NN	Transaction Rejected At Switch Or Intermediary		
PA	PA Exhausted/Not Renewable		
PB	Invalid Transaction Count For This Transaction Code	103, 109	
PC	M/I Claim Segment	111	
PD	M/I Clinical Segment	111	
PE	M/I COB/Other Payments Segment	111	

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
PF	M/I Compound Segment	111	
PG	M/I Coupon Segment	111	
PH	M/I DUR/PPS Segment	111	
PJ	M/I Insurance Segment	111	
PK	M/I Patient Segment	111	
PM	M/I Pharmacy Provider Segment	111	
PN	M/I Prescriber Segment	111	
PP	M/I Pricing Segment	111	
PR	M/I Prior Authorization Segment	111	
PS	M/I Transaction Header Segment	111	
PT	M/I Workers' Compensation Segment	111	
PV	Non-Matched Associated Prescription/Service Date	457	
PW	Non-Matched Employer ID	333	
PX	Non-Matched Other Payer ID	340	
PY	Non-Matched Unit Form/Route of Administration	451, 452, 600	
PZ	Non-Matched Unit Of Measure To Product/Service ID	407, 600	
P1	Associated Prescription/Service Reference Number Not Found	456	
P2	Clinical Information Counter Out Of Sequence	493	
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	447	
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	337	
P5	Coupon Expired	486	
P6	Date Of Service Prior To Date Of Birth	304, 401	

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	491	
P8	DUR/PPS Code Counter Out Of Sequence	473	
P9	Field Is Non-Repeatable		
RA	PA Reversal Out Of Order		
RB	Multiple Partial Fill Transactions Not Allowed		
RC	Different Drug Entity Between Partial & Completion		
RD	Mismatched Cardholder/Group ID-Partial To Completion	301, 302	
RE	M/I Compound Product ID Qualifier	488	
RF	Improper Order Of “Dispensing Status” Code On Partial Fill Transaction		
RG	M/I Associated Prescription/Service Reference Number On Completion Transaction	456	
RH	M/I Associated Prescription/Service Date On Completion Transaction	457	
RJ	Associated Partial Fill Transaction Not On File		
RK	Partial Fill Transaction Not Supported		
RM	Completion Transaction Not Permitted With Same “Date Of Service” As Partial Transaction	401	
RN	Plan Limits Exceeded On Intended Partial Fill Values	344, 345	
RP	Out Of Sequence “P” Reversal On Partial Fill Transaction		

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
RS	M/I Associated Prescription/Service Date On Partial Transaction	457	
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	456	
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment		
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions	478, 480	
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	471, 472	
R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions	458, 459	
R4	Procedure Modifier Code Invalid For Product/Service ID	407, 436, 459	
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals 06	407, 436	
R6	Product/Service Not Appropriate For This Location	307, 407, 436	
R7	Repeating Segment Not Allowed In Same Transaction		
R8	Syntax Error		
R9	Value In Gross Amount Due Does Not Follow Pricing Formula	430	
SE	M/I Procedure Modifier Code Count	458	
TE	M/I Compound Product ID	489	
UE	M/I Compound Ingredient Basis Of Cost Determination	490	

<b>Reject Code</b>	<b>Explanation</b>	<b>Field Number Possibly In Error</b>	<b>Possible Solutions</b>
VE	M/I Diagnosis Code Count	491	
WE	M/I Diagnosis Code Qualifier	492	
XE	M/I Clinical Information Counter	493	
ZE	M/I Measurement Date	494	

## 5.2 Host System Problems

Occasionally, providers may receive a message that indicates their network is having technical problems communicating with First Health Services.

NCPDP	Message
90	Host Hung Up

Host disconnected before session completed.

NCPDP	Message
92	System Unavailable/Host Unavailable

Processing host did not accept transaction or did not respond within time-out period.

NCPDP	Message
93	Planned Unavailable

Transmission occurred during scheduled downtime. First Health Services will provide system availability:

### System Hours of Availability

- 24-hour availability - Except Saturday into Sunday
  - ☐ Saturday down at 11:00 p.m., ET
  - ☐ Sunday up at 6:00 a.m., ET

NCPDP	Message
99	Host Processing Error

Do not retransmit claims.

## 5.3 DUR Fields

In those cases where provider-level overrides have been authorized, providers should use the following codes when applicable.

NCPDP	Message
88	DUR Reject Error

### DUR Reason for Service

The DUR Reason for Service (previously “Conflict Code”) is used to define the type of utilization conflict that was detected (NCPDP Field #439-E4).

Valid DUR Reason for Service Codes for the Kentucky Medicaid program are:

- **ER** NON-CONTROLLED EARLY REFILL 80%
- **DD** DRUG/ DRUG INTERACTION
- **TD** THERAPEUTIC DUPLICATION
- **ID** DUPLICATE INGREDIENT

NCPDP	Message
E4	M/I DUR Conflict/Reason for Service Code

### DUR Professional Service

The DUR Professional Service (previously “Intervention Code”) is used to define the type of interaction or intervention that was performed by the pharmacist (NCPDP Field #440-E5).

Valid DUR Professional Service Codes for the Kentucky Medicaid program are:

- **GP** generic product selection
- **M0** prescriber consulted
- **MR** medication review
- **PH** patient medication history
- **P0** patient consulted
- **R0** RPh consulted other source

NCPDP	Message
E5	M/I DUR Intervention/Professional Service Code

## DUR Result of Service

The DUR Result of Service (previously “Outcome Code”) is used to define the action taken by the pharmacist in response to a ProDUR Reason for Service or the result of a pharmacist’s professional service (NCPDP Field #441-E6).

Valid DUR Result of Services Codes for the Kentucky Medicaid program are:

- **1A** filled as is, false positive
- **1B** filled prescription as is
- **1C** filled with different dose
- **1D** filled with different directions
- **1E** filled with different drug
- **1F** filled with different quantity
- **1G** filled with prescriber approval
- **2A** prescription not filled
- **2B** not filled, directions clarified
- **3C** discontinued
- **3D** regimen changed
- **3E** therapy changed

NCPDP	Message
E6	M/I DUR Outcome/Result of Service Code

### Note:

If a High Dose rejection is returned on an atypical antipsychotic drug, the pharmacy or prescriber must fax the *Mental Health Drug Prior Authorization Request Form* to the First Health Services Clinical Call Center.

## **6.0 Provider Reimbursement**

### **6.1 Provider Payment Algorithms**

- The provider is paid at the lesser of:
  - ☐ AWP - 14% for generic + dispense fee
  - ☐ AWP – 15% for brand + dispense fee
  - ☐ FUL + dispense fee
  - ☐ MAC + dispense fee
  - ☐ Usual and Customary
  - ☐ Gross Amount Due

#### **340b**

- Providers should submit acquisition costs as U/C. Standard Payment Algorithm used.

### **6.2 Provider Dispensing Fees**

- Brand = \$4.50
- Generic = \$5.00

## Appendix A: Universal Claim Form

### Universal Claim Form

The *Universal Claim Form (UCF)* will be required for all paper claims. UCFs can be obtained from your wholesaler (see *Section 1.1 - Important Telephone Numbers for Universal Claim Forms*) and should be submitted to First Health Services. See *Section 1.2 - Addresses* for Provider Paper Claims Billing Address.

### How to Complete 5.1 UCF Form

1. Fill in all applicable areas on the front of the form.
2. Verify patient information is correct and that patient named is eligible for benefits.
3. Patient signs certification on front side for prescription(s) received.
4. Enter Compound Rx in the Product Service ID area of claim block #1 and list the first ingredient name, NDC, quantity, and cost in the area below. On back of claim form, provide information for the remaining ingredients. Claim block #2 should not be used when submitting claims for compounds. **Please use a separate claim form for each compound prescription.**
5. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
6. Limit 1 set of DUR/PPS codes per claim.
7. The medication being billed must match what is being/was dispensed.
8. Each area is numbered. Fill each area using the following codes:

**Definitions/Values**

<b>Definitions</b>	<b>Values</b>
<b>OTHER COVERAGE CODE</b>	1 = No other coverage identified 2 = Other coverage exists payment collected 3 = Other coverage exists this claim not covered 4 = Other coverage exists payment not collected 6 = Other coverage denied not a participating provider 7 = Other coverage exists not in effect at time of service
<b>PERSON CODE</b>	Code assigned to a specific person within a family. All members are "01."
<b>PATIENT GENDER CODE</b>	0 = Not specified 1 = Male 2 = Female
<b>PATIENT RELATIONSHIP CODE</b>	1 = Cardholder
<b>SERVICE PROVIDER ID QUALIFIER</b>	05 = Medicaid ID or 01 = National Provider Identifier (NPI) 99 = Other
<b>CARRIER ID</b>	Carrier code is assigned in the Worker's Compensation Program.
<b>CLAIM/REFERENCE ID</b>	Identifies the claim number assigned by Worker's Compensation Program.
<b>PRESCRIPTION SERVICE REFERENCE # QUALIFIER</b>	Blank = Not Specified 1 = Rx billing 2 = Service bill
<b>QUANTITY DISPENSED</b>	Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).
<b>PRODUCT SERVICE ID QUALIFIER</b>	Code qualifying the value in Product/Service ID (407-07). 03 = National Drug Code (NDC)
<b>PRIOR AUTHORIZATION TYPE CODE</b>	0 = Not Specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption From Co-Payment 6 = Family Planning Indicator 8 = Payer Defined Exemption

Definitions	Values
<b>PRESCRIBER ID QUALIFIER</b>	08 = State License Number or 01 = National Provider Identifier (NPI)
<b>DUR/PROFESSIONAL SERVICE CODES</b>	For values, refer to current NCPDP data dictionary. A = Reason for Service B = Professional Service Code C = Result of Service
<b>BASIS OF COST DETERMINATION</b>	01 = AWP (average wholesale price) 07 = Usual and Customary 09 = Other
<b>PROVIDER ID QUALIFIER</b>	05 = Medicaid ID or 01 = National Provider Identifier (NPI)
<b>DIAGNOSIS CODE QUALIFIER</b>	Blank = Not Specified 00 = Not Specified 01 = International Classification of Diseases (ICD9) 99 = Other
<b>OTHER PAYER ID QUALIFIER</b>	99 = Other

**Universal Claim Form - Page 1 - Sample**

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1942-1109-9227

**TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES**

**PERF**

**UNIVERSAL CLAIM FORM (UCF)**

Copyright © by NCPDP 1997, 1999, 1998, 1997, 1996, 2000

**1**

**2**

**SCREENS: BOX 10%, TEXT 11%.**

**1**

**2**

**PERF**

**ATTENTION RECIPIENT  
PLEASE READ  
CERTIFICATION  
STATEMENT ON  
REVERSE SIDE**

**FOR OFFICE  
USE ONLY**

**WORKERS COMP. INFORMATION**

**EMPLOYER  
NAME**

**ADDRESS**

**CITY**

**STATE**

**ZIP CODE**

**CARRIER  
I.D. (6)**

**EMPLOYER  
PHONE NO.**

**DATE OF  
INJURY**

**CLAIM (7)  
REFERENCE I.D.**

**I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.**

**PATIENT /  
AUTHORIZED REPRESENTATIVE**

**PRESCRIPTION / SERV. REF. #**

**QUAL (8)**

**DATE WRITTEN**

**MM DD CCYY**

**DATE OF SERVICE**

**MM DD CCYY**

**FILL#**

**QTY DISPENSED (9)**

**DAYS SUPPLY**

**PRODUCT / SERVICE I.D.**

**QUAL (10)**

**DAW CODE**

**PRIOR AUTH #  
SUBMITTED**

**PA TYPE (11)**

**PRESCRIBER I.D.**

**QUAL (12)**

**DUR/PPS CODES (13)**

**BASIS CODE (14)**

**PROVIDER I.D.**

**QUAL (15)**

**DIAGNOSIS CODE**

**QUAL (16)**

**OTHER PAYER DATE**

**MM DD CCYY**

**OTHER PAYER I.D.**

**QUAL (17)**

**OTHER PAYER REJECT CODES**

**USUAL & CUST.  
CHARGE**

**INGREDIENT  
COST  
SUBMITTED**

**DISPENSING  
FEE  
SUBMITTED**

**INCENTIVE  
AMOUNT  
SUBMITTED**

**OTHER  
AMOUNT  
SUBMITTED**

**SALES  
TAX  
SUBMITTED**

**GROSS  
AMOUNT DUE  
SUBMITTED**

**PATIENT  
PAID  
AMOUNT**

**OTHER PAYER  
AMOUNT  
PAID**

**NET  
AMOUNT  
DUE**

[illegible]

## Appendix B: Payer Specification

### Overview

<b>Payer:</b>	Kentucky Medicaid
<b>Processor:</b>	First Health Services
<b>Information Source:</b>	First Health Services
<b>Effective as of:</b>	12/04/2004
<b>Document Date:</b>	07/01/2007
<b>Technical Call Center (Provider Help Desk)</b>	1-800-432-7005
<b>Certification Help Number:</b>	1-804-217-5060
<b>Other Versions Supported:</b>	No

## NCPDP Version 5.1 Transaction Types

Lower Version Transaction Code	Lower Version Transaction Name	Transaction Code	Transaction Name	Transaction Support Requirements
00	Eligibility Verification	E1	Eligibility Verification	Supported <12/04/2004>.
01 – 04	Rx Billing	B1	Billing	Required <12/04/2004>.
11	Rx Reversal	B2	Reversal	Required <12/04/2004>.
21 – 24	Rx Downtime Billing	N/A	N/A	Not supported in v.5.1.
31 – 34	Rx Re-billing	B3	Re-bill	Required <12/04/2004>.
41	Prior Authorization Request with Request for Payment	P1	Prior Authorization Request and Billing	Not required.
45	Prior Authorization Inquiry	P3	Prior Authorization Inquiry	Not required.
46	Prior Authorization Reversal	P2	Prior Authorization Reversal	Not required.
51	Prior Authorization Request Only	P4	Prior Authorization Request Only	Not required.

## NCPDP Version 5.1 Segments

Segment	Transaction Codes								Support Requirements
	E1	B1	B2	B3	P1	P2	P3	P4	Some segments may be required at a future date to be determined.
Header	M	M	M	M	M	M	M	M	Required <12/04/2004>.
Patient	S	S	S	S	S	S	S	S	Required <12/04/2004>.
Insurance	M	M	S	M	M	S	M	M	Required <12/04/2004>.
Claim	N	M	M	M	M	M	M	M	Required <12/04/2004>.
Pharmacy Provider	S	S	N	S	S	S	S	S	No planned requirements at this time; <b>may be required at a future date.</b>
Prescriber	N	S	N	S	S	S	S	S	Required <12/04/2004>.
COB/Other Payments	N	S	N	S	S	N	S	S	Required <12/04/2004>.
Worker's Comp	N	S	N	S	S	S	S	S	Not required.
DUR/ PPS	N	S	S	S	S	S	S	S	Required <12/04/2004>.
Pricing	N	M	S	M	M	S	S	S	Required <12/04/2004>.
Coupon	N	S	N	S	S	S	S	S	No planned requirements at this time; <b>may be required at a future date.</b>
Compound	N	S	N	S	S	S	S	S	<b>Will be required February 1, 2005.</b>
PA	N	S	N	S	M	S	M	M	No planned requirements at this time; <b>may be required at a future date.</b>
Clinical	N	S	N	S	S	N	N	S	Required <12/04/2004>

## Program Highlights

- The software/certification ID will control whether 5.1 claims will be accepted by the production system. Your software vendor will receive a number upon certification with First Health Services. This number must be included on the transaction header segment. Software vendors must be certified. Contact [Vendor\\_Certification@fhsc.com](mailto:Vendor_Certification@fhsc.com) or 804-217-5060.
- Compounds will be processed on-line using the Multi-Ingredient Compound Segment effective 02/01/2005. Providers should use existing protocols prior to that time.
- Coordination of Benefits will be supported via the COB segment only.
- In cases where multiple iterations of a field (“repeating fields”) are allowed, the maximum number of iterations has been indicated.
- Partial fills will be supported.
- Reversals will match on Provider Number, RX Number, DOS and Product (NDC).
- Any/All submitted data elements will be edited for valid format and values.
- Provider software should support any/all data elements on the required segments.

## Field Requirement Legend

Code	Description
M	Designated as <b>MANDATORY</b> in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. These fields must be sent if the segment is required for the transaction.
S	Designated as <b>SITUATIONAL</b> in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. It is necessary to send these fields in noted situations. Some fields designated as situational by NCPDP may be required for all Kentucky Medicaid transactions. Some fields designated as SITUATIONAL by NCPDP may be required for Kentucky Medicaid transactions where specific conditions are met.
X***R***	The “R***” indicates that the field is repeating.
<b>NOTES:</b> <ul style="list-style-type: none"> <li>Specific field values that are required for the program are identified as “<b>KENTUCKY MEDICAID VALUES SUPPORTED.</b>”</li> <li>There may be additional information regarding field values in the Provider Manual.</li> <li>Fields listed as “Not required for this program” at this time may be required in the future.</li> <li>All <b>MANDATORY</b> fields are required. All bolded <b>SITUATIONAL</b> fields are required as indicated.</li> </ul>	

## Transactions

### *Transaction Header*

Segment		Segment MANDATORY for all transactions.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
101-A1	BIN NUMBER	M	011529
102-A2	VERSION/RELEASE NUMBER	M	51
103-A3	TRANSACTION CODE	M	B1, B2, B3
104-A4	PROCESSOR CONTROL NUMBER	M	P022011529
109-A9	TRANSACTION COUNT	M	B1 = 1-4 (except multi-ingredient compound <when implemented> = 1) B2 = 1-4 (except multi-ingredient compound <when implemented> = 1) B3 = 1-4 (except multi-ingredient compound <when implemented> = 1)
202-B2	SERVICE PROVIDER ID QUALIFIER	M	05 = Medicaid ID 01 = National Provider Identifier (NPI)
201-B1	SERVICE PROVIDER ID	M	KY Medicaid ID or National Provider Identifier (NPI)
401-D1	DATE OF SERVICE	M	Format = CCYYMMDD
110-AK	SOFTWARE VENDOR/ CERTIFICATION ID	M	Assigned when vendor is certified with FIRST HEALTH SERVICES; will reject if missing or not valid.

**Patient**

Segment		Segment REQUIRED for B1 & B3 transactions.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	01 = Patient Segment
331-CX	PATIENT ID QUALIFIER	S	
332-CY	PATIENT ID	S	
304-C4	DATE OF BIRTH	S	
305-C5	PATIENT GENDER CODE	R	
310-CA	PATIENT FIRST NAME	R	
311-CB	PATIENT LAST NAME	R	
322-CM	PATIENT STREET ADDRESS	S	
323-CN	PATIENT CITY ADDRESS	S	
324-CO	PATIENT STATE / PROVINCE ADDRESS	S	
325-CP	PATIENT ZIP/POSTAL ZONE	S	
326-CQ	PATIENT PHONE NUMBER	S	
307-C7	PATIENT LOCATION	S	
333-CZ	EMPLOYER ID	N	
334-1C	SMOKER / NON-SMOKER CODE	N	

Segment		Segment REQUIRED for B1 & B3 transactions.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
335-2C	PREGNANCY INDICATOR	RW	1 = not pregnant 2 = pregnant Enter “2” to indicate the patient is pregnant and to waive co-payment. After 60-days postpartum, stop entering “2” to override co-payment.

### Insurance

Segment		Segment MANDATORY for E1, B1, & B3 transactions.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	04 = Insurance Segment
302-C2	CARDHOLDER ID	M	Kentucky Medicaid ID Number <patient specific>
312-CC	CARDHOLDER FIRST NAME	S	
313-CD	CARDHOLDER LAST NAME	S	
314-CE	HOME PLAN	S	
524-FO	PLAN ID	S	
309-C9	ELIGIBILITY CLARIFICATION CODE	S	
336-8C	FACILITY ID	S	
301-C1	GROUP ID	R	Required for this program: KYMEDICAID
303-C3	PERSON CODE	S	
306-C6	PATIENT RELATIONSHIP CODE	S	

**Claim**

Segment		Segment MANDATORY for B1, B2, & B3 transactions.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	07 = Claim Segment
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	1 = Rx billing
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	03 = NDC
407-D7	PRODUCT/SERVICE ID	M	NDC
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE #	RW	<ul style="list-style-type: none"> <li>Required when the “completion” transaction in a partial fill (Dispensing Status (343-HD) = “C” (Completed)) and the Prescription/Service Reference Number (402-D2) changed from the “P” (Partial Fill).</li> <li>Required when the “P” (Partial Fill) is not the original fill and the Prescription/Service Reference Number (402-D2) has not changed.</li> </ul>
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	RW	<ul style="list-style-type: none"> <li>Required when the “completion” transaction in a partial fill (Dispensing Status (343-HD) = “C” (Completed)).</li> <li>Required when Associated Prescription/Service Reference Number (456-EN) is used.</li> <li>Required when the “P” (Partial Fill) transaction is not the original fill.</li> </ul>
458-SE	PROCEDURE MODIFIER CODE COUNT	S	
459-ER	PROCEDURE MODIFIER CODE	S***R***	
442-E7	QUANTITY DISPENSED	R	Required for this program.

Segment		Segment MANDATORY for B1, B2, & B3 transactions.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
403-D3	FILL NUMBER	R	Required for this program.
405-D5	DAYS SUPPLY	R	Required for this program.
406-D6	COMPOUND CODE	R	Required for this program.
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	R	Required for this program.
414-DE	DATE PRESCRIPTION WRITTEN	R	Required for this program.
415-DF	NUMBER OF REFILLS AUTHORIZED	R	Required for this program.
419-DJ	PRESCRIPTION ORIGIN CODE	S	
420-DK	SUBMISSION CLARIFICATION CODE	RW	Required when needed to provide additional information for coverage purposes.
460-ET	QUANTITY PRESCRIBED	S	
308-C8	OTHER COVERAGE CODE	RW	Required when needed for COB.
429-DT	UNIT DOSE INDICATOR	RW	Required when needed to identify unit dose packaging.
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	S	
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE	S	
446-EB	ORIGINALLY PRESCRIBED QUANTITY	S	
330-CW	ALTERNATE ID	S	
454-EK	SCHEDULED PRESCRIPTION ID NUMBER	S	

Segment		Segment MANDATORY for B1, B2, & B3 transactions.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
600-28	UNIT OF MEASURE	R	Required for this program.
418-DI	LEVEL OF SERVICE	RW	Required when overriding for an emergency fill. 03 = Emergency
461-EU	PRIOR AUTHORIZATION TYPE CODE	RW	Required when needed to provide additional information for coverage purposes.
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	S	
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID	S	
464-EX	INTERMEDIARY AUTHORIZATION ID	S	
343-HD	DISPENSING STATUS	RW	Required when submitting a partial fill or the completion of a partial fill.
344-HF	QUANTITY INTENDED TO BE DISPENSED	RW	Required when submitting a partial fill or the completion of a partial fill.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	RW	Required when submitting a partial fill or the completion of a partial fill.

### ***Pharmacy Provider***

Segment NOT REQUIRED at this time. Fields intentionally not listed. Possible future use.

**Prescriber**

Segment		Segment REQUIRED for B1 & B3 transaction.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	03 = Prescriber Segment
466-EZ	PRESCRIBER ID QUALIFIER	R	08 = State License Number
411-DB	PRESCRIBER ID	R	State License Number (prescriber specific)
467-1E	PRESCRIBER LOCATION CODE	S	
427-DR	PRESCRIBER LAST NAME	S	
498-PM	PRESCRIBER PHONE NUMBER	S	
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	S	
421-DL	PRIMARY CARE PROVIDER ID	S	
469-H5	PRIMARY CARE PROVIDER LOCATION CODE	S	
470-4E	PRIMARY CARE PROVIDER LAST NAME	S	

**COB**

Segment		Segment REQUIRED for transactions B1 & B3 if there is OTHER PAYER information.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	05 = Coordination of Benefits/ Other Payments Segment
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	M Max = 3	
338-5C	OTHER PAYER COVERAGE TYPE	M***R*** Max = 3	
339-6C	OTHER PAYER ID QUALIFIER	S***R*** Max = 3	Not required at this time.
340-7C	OTHER PAYER ID	S***R*** Max = 3	Not required at this time.
443-E8	OTHER PAYER DATE	R***R*** Max = 3	Required for this program.
341-HB	OTHER PAYER AMOUNT PAID COUNT	RW	Required when submitting Other Payer Amount Paid.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	RW***R*** Max = 3	Required when submitting for this program.
431-DV	OTHER PAYER AMOUNT PAID	RW***R*** Max = 3	Required for this program.
471-5E	OTHER PAYER REJECT COUNT	RW	Required when the primary has rejected the claim.
472-6E	OTHER PAYER REJECT CODE	RW	Required when the primary has rejected the claim.

## Workers' Compensation

Segment NOT REQUIRED. Fields intentionally not listed.

## DUR/PPS

Segment		Segment REQUIRED for transactions B1 and B3 if there is DUR information.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	08 = DUR/ PPS Segment
473-7E	DUR/PPS CODE COUNTER	RW***R Max = 9	Required when needed to communicate DUR information.
439-E4	REASON FOR SERVICE CODE	RW***R Max = 9	Required when needed to communicate DUR information. See “Pro-DUR” section in Provider Manual.
440-E5	PROFESSIONAL SERVICE CODE	RW***R Max = 9	Required when needed to communicate DUR information. See “Pro-DUR” section in Provider Manual.
441-E6	RESULT OF SERVICE CODE	RW***R Max = 9	Required when needed to communicate DUR information. See “Pro-DUR” section in Provider Manual.
474-8E	DUR/PPS LEVEL OF EFFORT	RW***R Max = 9	Required when needed to communicate DUR information. See “Pro-DUR” section in Provider Manual.
475-J9	DUR CO-AGENT ID QUALIFIER	S***R Max = 9	
476-H6	DUR CO-AGENT ID	S***R Max = 9	

**Compound**

Segment		Segment REQUIRED on/about February 1, 20065. Providers will be notified.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	10 = Compound Segment
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	
452-EH	COMPOUND ROUTE OF ADMINISTRATION	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M	Maximum of 25 iterations
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***R***	
489-TE	COMPOUND PRODUCT ID	M***R***	
448-ED	COMPOUND INGREDIENT QUANTITY	M***R***	
449-EE	COMPOUND INGREDIENT DRUG COST	R***R***	Required for this program.
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	S***R***	

**Prior Authorization**

Segment NOT REQUIRED at this time; fields intentionally not listed. Future use. Specifications will be provided at a later date.

**Pricing**

Segment		Segment MANDATORY for B1 & B3.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	11 = Pricing Segment
409-D9	INGREDIENT COST SUBMITTED	R	Required for this program. Zero is a valid value.
412-DC	DISPENSING FEE SUBMITTED	R	Required if its value has an effect on the Gross Amount Due (430-DU) calculation. Zero is a valid value.
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	S	
433-DX	PATIENT PAID AMOUNT SUBMITTED	S	Do not submit any value other than zero in this field.
438-E3	INCENTIVE AMOUNT SUBMITTED	S	
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	S***R*** Max = 3	
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	S***R*** Max = 3	
480-H9	OTHER AMOUNT CLAIMED SUBMITTED	R***R*** Max = 3	
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	S	
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	S	
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	S	

Segment		Segment MANDATORY for B1 & B3.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	S	
426-DQ	USUAL AND CUSTOMARY CHARGE	R	Required for this program.
430-DU	GROSS AMOUNT DUE	R	Effective January 4, 2005 this field will be used in “lesser of” pricing.
423-DN	BASIS OF COST DETERMINATION	S	

### ***Coupon***

Segment NOT REQUIRED at this time; fields intentionally not listed. Possible future use.

**Clinical**

Segment		Segment REQUIRED for B1 and B3 transactions if designated clinical information is needed for drug coverage consideration.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	13 = Clinical Segment
491-VE	DIAGNOSIS CODE COUNT	S Max = 5	
492-WE	DIAGNOSIS CODE QUALIFIER	S***R*** Max = 5	01 = International Classification of Diseases (ICD9)
424-DO	DIAGNOSIS CODE	S***R*** Max = 5	All decimal points are explicit
493-XE	CLINICAL INFORMATION COUNTER	S	
494-ZE	MEASUREMENT DATE	S	
495-H1	MEASUREMENT TIME	S	
496-H2	MEASUREMENT DIMENSION	S	
497-H3	MEASUREMENT UNIT	S	
499-H4	MEASUREMENT VALUE	S	

## Response Segment/Field Requirements - PAID (or Duplicate of Paid) Response

### *Transaction Header*

Segment		Segment MANDATORY for all transactions.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
102-A2	VERSION/RELEASE NUMBER	M	Same value as in request billing
103-A3	TRANSACTION CODE	M	Same value as in request billing
109-A9	TRANSACTION COUNT	M	Same value as in request billing
501-F1	HEADER RESPONSE STATUS	M	A
202-B2	SERVICE PROVIDER ID QUALIFIER	M	Same value as in request billing
201-B1	SERVICE PROVIDER ID	M	Same value as in request billing
401-D1	DATE OF SERVICE	M	Same value as in request billing

### *Response Message*

Segment		Segment SITUATIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	20 = Response Message Segment
504-F4	MESSAGE	S	Required when text is needed for clarification or detail.

**Response Insurance**

Segment		Segment SITUATIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	25 = Response Insurance Segment
301-C1	GROUP ID	S	
524-FO	PLAN ID	S	
545-2F	NETWORK REIMBURSEMENT ID	S	
568-J7	PAYER ID QUALIFIER	S	
569-J8	PAYER ID	S	

**Response Status**

Segment		Segment SITUATIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	21 = Response Status Segment
112-AN	TRANSACTION RESPONSE STATUS	M	P = Paid D = Duplicate
503-F3	AUTHORIZATION NUMBER	S	Returned when needed to identify the transaction.
510-FA	REJECT COUNT	S	
511-FB	REJECT CODE	S***R***	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	S***R***	
547-5F	APPROVED MESSAGE CODE COUNT	S	
548-6F	APPROVED MESSAGE CODE	S***R***	
526-FQ	ADDITIONAL MESSAGE INFORMATION	S	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	S	
550-8F	HELP DESK PHONE NUMBER	S	

**Response Claim**

Segment		Segment SITUATIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	22 = Response Claim Segment
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	M	1 = Rx billing
402-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	M	
551-9F	PREFERRED PRODUCT COUNT	S	
552-AP	PREFERRED PRODUCT ID QUALIFIER	S***R***	
553-AR	PREFERRED PRODUCT ID	S***R***	
554-AS	PREFERRED PRODUCT INCENTIVE	S***R***	
555-AT	PREFERRED PRODUCT CO PAY INCENTIVE	S***R***	
556-AU	PREFERRED PRODUCT DESCRIPTION	S***R***	

**Response Pricing**

Segment		Segment SITUATIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	23 = Response Pricing Segment
505-F5	PATIENT PAY AMOUNT	S	Returned when the processor determines that the patient has payment responsibility for part/ all of the claim.
506-F6	INGREDIENT COST PAID	S	Required when this value is used to arrive at the final reimbursement.
507-F7	DISPENSING FEE PAID	S	Required when this value is used to arrive at the final reimbursement.
557-AV	TAX EXEMPT INDICATOR	S	
558-AW	FLAT SALES TAX AMOUNT PAID	S	
559-AX	PERCENTAGE SALES TAX AMOUNT PAID	S	
560-AY	PERCENTAGE SALES TAX RATE PAID	S	.
561-AZ	PERCENTAGE SALES TAX BASIS PAID	S	
521-FL	INCENTIVE AMOUNT PAID	S	
562-J1	PROFESSIONAL SERVICE FEE PAID	S	
563-J2	OTHER AMOUNT PAID COUNT	S	
564-J3	OTHER AMOUNT PAID QUALIFIER	S***R***	
565-J4	OTHER AMOUNT PAID	S***R***	
566-J5	OTHER PAYER AMOUNT RECOGNIZED	S	
509-F9	TOTAL AMOUNT PAID	S	

Segment		Segment SITUATIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	S	
523-FN	AMOUNT ATTRIBUTED TO SALES TAX	S	
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT	S	
513-FD	REMAINING DEDUCTIBLE AMOUNT	S	
514-FE	REMAINING BENEFIT AMOUNT	S	
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	S	
518-FI	AMOUNT OF INSURANCE/CO-INSURANCE	S	
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	S	
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM	S	
346-HH	BASIS OF CALCULATION – DISPENSING FEE	S	
347-HJ	BASIS OF CALCULATION – CO PAY	S	
348-HK	BASIS OF CALCULATION – FLAT SALES TAX	S	

Segment		Segment SITUATIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
349-HM	BASIS OF CALCULATION – PERCENTAGE SALES TAX	S	

**Response DUR/PPS**

Segment		Segment SITUATIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	24 = Response DUR/ PPS Segment
567-J6	DUR/ PPS RESPONSE CODE COUNTER	S***R***	
439-E4	REASON FOR SERVICE CODE	S***R***	See Provider Manual for allowed values. <client>
528-FS	CLINICAL SIGNIFICANCE CODE	S***R***	
529-FT	OTHER PHARMACY INDICATOR	S***R***	0 = Not specified 1 = Your pharmacy 2 = Other pharmacy in same chain 3 = Other pharmacy
530-FU	PREVIOUS DATE OF FILL	S***R***	
531-FV	QUANTITY OF PREVIOUS FILL	S***R***	
532-FW	DATABASE INDICATOR	S***R***	
533-FX	OTHER PRESCRIBER INDICATOR	S***R***	0 = Not specified 1 = Same prescriber 2 = Other prescriber
544-FY	DUR FREE TEXT MESSAGE	S***R***	Required when text is needed for additional clarification.

**Response Prior Authorization**

Segment NOT REQUIRED at this time; fields intentionally not listed. Future use. Specifications will be provided at a later date.

## Response Segment/Field Requirements - REJECT Response

### *Transaction Header*

Segment		Segment MANDATORY for all transactions.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
102-A2	VERSION/RELEASE NUMBER	M	Same value as in request billing
103-A3	TRANSACTION CODE	M	Same value as in request billing
109-A9	TRANSACTION COUNT	M	Same value as in request billing
501-F1	HEADER RESPONSE STATUS	M	R
202-B2	SERVICE PROVIDER ID QUALIFIER	M	Same value as in request billing
201-B1	SERVICE PROVIDER ID	M	Same value as in request billing
401-D1	DATE OF SERVICE	M	Same value as in request billing

### *Response Message*

Segment		Segment OPTIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	20 = Response Message Segment
504-F4	MESSAGE	S	Required if text is needed for clarification or detail.

**Response Status**

Segment		Segment OPTIONAL.	
Field	Field Name	Mandatory/ Situational	Kentucky Medicaid Values Supported
111-AM	SEGMENT IDENTIFICATION	M	21 = Response Status Segment
112-AN	TRANSACTION RESPONSE STATUS	M	R = Rejected
503-F3	AUTHORIZATION NUMBER	S	Returned when needed to identify the transaction
510-FA	REJECT COUNT	S	
511-FB	REJECT CODE	S***R***	See Provider Manual for list of applicable error codes.
546-4F	REJECT FIELD OCCURRENCE INDICATOR	S***R***	
547-5F	APPROVED MESSAGE CODE COUNT	S	
548-6F	APPROVED MESSAGE CODE	S***R***	
526-FQ	ADDITIONAL MESSAGE INFORMATION	S	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	S	
550-8F	HELP DESK PHONE NUMBER	S	